

EXHIBIT A

GUIS 16 FEB '00

Mutual of Omaha
Commutaries

APPROVED

DATE

3-13-00

HOME OFFICE USE ONLY

Division 1
Class 5
Effective Date 4/1/00

Benefit Increase Option Application

GUIS 10 MAR '00

Group Name Bell Atlantic Policy Number GMLC-2V65

1. Applicant Information

Name MARY A. FROEHLICH Social Security Redacted 558Address 334 DEVON WAYCity WEST CHESTER State PA Zip Code 19380Daytime Telephone Number. (610) 436-6363Date of Birth Redacted 23Height 5'2" Weight 115 Sex F

2. Current Premium Payment Method (Check One)

☐ Payroll Deduction☒ Pension Deduction☐ Direct Bill ☐ Quarterly ☐ Semiannually ☐ AnnuallyPLEASE RETURN THE
ATTACHED FORM TO THE
ATTENTION OF:
S1 - GROUP UNDERWRITING
INDIVIDUAL SELECTION
MLUG021

3. Amount of Increase Being Applied For

\$20

4. HEALTH INFORMATION

- (a) In the past five years, have you ever had, been advised by a physician that you had or received treatment for:
-
- (Circle conditions answered "Yes" and give details on reverse side.)

	Yes	No
(1) High blood pressure, chest pain, heart attack or stroke?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(2) Alzheimer's disease, seizures or convulsions, paralysis, mental or nervous disorder, or brain disease or disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(3) Cancer, leukemia, malignant growth or any form of tumor?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(4) Diabetes, kidney disease or disorder, or any other disorder of the urinary system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(5) Asthma, emphysema or any lung disease or other respiratory disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(6) Arthritis, neuritis, rheumatism, gout or any disease of, disorder or injury to the back, spine, bones, muscles or joints?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(7) Alcohol abuse, drug abuse, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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\$5040

(8) Any loss of hearing, or loss of or partial loss of use of any eye, limb, hand or foot? ☐ ☒

b) Have you ever used a wheelchair, crutches, cane, walker or other mobility aid (i.e., braces, prosthesis, etc.)? If "Yes," give details below. ☐ ☒

(c) Within the past 12 months, have you used medication, received medical treatment or been confined to a hospital, nursing home or convalescent facility? If "Yes," give details below. ☐ ☒

(d) Within the past five years, have you had any mental or physical disorder or bodily injury not listed above? If "Yes," give details below. ☐ ☒

Ques No.	Condition, Injury, Symptoms of Ill Health or Findings of Examination (if Operation Performed, State Type)	Month and Year	Duration	Degree of Recovery	Name, Address and ZIP Code of Hospital and Attending Physician
4/a(1)	TAKES ALTACE BUT		6 yrs +	100%	DR. STADLIN
	DOESN'T HAVE HIGH				PAOLI HOSPITAL
	BLOOD				PAOLI, PA
138	2/28 AS OF 2/28/00				

(e) Can you perform each of the activities of daily living listed below without physical or mechanical assistance or supervision? (If any question is answered "No," give details below.)

	Yes	No		Yes	No
(1) Get in or out of bed	<input checked="" type="checkbox"/>	<input type="checkbox"/>	(4) Dress	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(2) Take medications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	(5) Toilet	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(3) Eat, prepare meals	<input checked="" type="checkbox"/>	<input type="checkbox"/>	(6) Bathe	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Details for "No" answers:

STATEMENT OF APPLICATION

I apply for an increase in my Long-Term Care Maximum Daily Benefit for myself. I understand that the increase will not begin until Mutual of Omaha approves the increase. I have given the above answers to obtain this increase. These answers are true and complete to the best of my knowledge and belief. I know that the increase could be void if answers are not true and complete. I understand I am not eligible for this increase if I am currently receiving long-term care services. I hereby certify I am not currently receiving any long-term care services.

To: Physicians, Hospitals and Other Providers of Health Care Services, Insurers, Employers and Group Policyholders

You may give Mutual of Omaha health, job status or other insurance information about me. You may also give this information about me. You may also give this information to Mutual of Omaha's reinsurer or to the Policy Administrator. Health information includes all records about: (a) physical and mental health, (b) medical history and (c) drug and alcohol use. This information will be used to evaluate my application. This form will be valid for 30 months from when it is signed. A photocopy of this form is as valid as the original. A copy of this form will be provided and will be made a part of my certificate. I understand the certificate is subject to all policy provisions including payment of premium.

Mary A. Prochaska
(Signature of Applicant)

Feb. 9, 2000
(Date)

EXHIBIT B



April 10, 2000

Mary Froehlich
334 Devon Way
West Chester, PA 19380

GMLC-2V65 Division 00001
Applicant Mary Froehlich
SSN *Redacted*

Dear Ms. Froehlich,

We have received your request to increase your original Maximum Daily Benefit by \$20 in accordance with the Benefit Increase Provision of your certificate.

The requested increase has been approved and will become effective on April 1, 2000. The additional premium for this increase is \$50.40 and your total monthly premium will now be \$158.40.

If you were required to complete a health application, a copy for your records is attached.

If you have questions, or if we can be of any service, please call the Long-Term Care Customer Service Line at 1-800-877-1052 from 8:00 A.M. to 4:30 P.M. Central Time Monday through Friday (except holidays).

Thank you for your continued coverage with Mutual of Omaha.

Sincerely,

Mutual of Omaha
Group Long-Term Care